Natural Healthcare Center
Integrated Health & Wellness Programs

West End Physical Therapy

Patient Questionnaire (Please print clearly)

For office use only: New ____ Reactivated ____ PI ____

Section 1:

Name (First)_______________________________ (Last) _______________________________

Address ______________________________**City**__________________ **State** ________ **Zip** ______________

Social Security # ____________________ **Gender** ☐ Male ☐ Female **Date of Birth**: ____________________

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated **Spouse Name** ____________________

Language preference: ☐ English ☐Spanish ☐Other:____________ **Ethnicity** (Italian, Polish, etc.):____________________

Race ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Middle-Eastern ☐ Pacific Islander ☐ Native American

Home Phone# ______________________ **Cell Phone#** ______________________________

Email Address: ____

Parent/Guardian Name:__________________________________ **Relation to patient:** ____________

Parent/Guardian Phone: __________________ **Parent/Guardian email address:** ____________________

Emergency Contact Name:________________________ **Relation:**____________ **Phone:**______________

Your Occupation ____________________Employer____

Address ______________________________City__________________ State ________ Zip ______________

Person who holds primary health insurance, if other than yourself: Name ______________________________
Date of Birth __________ Relation: ____________Employer: ______________ Insurance Carrier: ______________
Person who holds secondary health insurance, if other than yourself: Name ______________________________
Date of Birth __________ Relation: ____________Employer: ______________ Insurance Carrier: ______________

Do you have an HSA/FSA (Health Savings or Flexible Spending Account)? ☐ Yes ☐ No If so, who administers? ____________

Do you have a pacemaker? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No Height: _____ft. _____inches Weight: _______lbs.

Section 2:

Medications

Date Started	Medication	Dosage

Allergies to Medication

Medicine	Reaction

Family Medical History:

Cancer Diabetes Heart Disease Stroke Depression Seizure

High Blood Pressure Thyroid Disease Other: ______________________

Section 3:

Have you had or currently have any of the following conditions?

Musculoskeletal/Pain
- ☐ Osteoporosis/Osteopenia
- ☐ Scoliosis
- ☐ Muscle Pain
- ☐ Arm Numb/Tingling
- ☐ Leg Numb/Tingling
- ☐ Neck Pain
- ☐ Middle Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain
- ☐ Elbow Pain
- ☐ Hand/Wrist Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Ankle/Foot Pain
- ☐ Joint Pain – where? ________________
- ☐ Other ____________________________

Gastrointestinal
- ☐ Irritable Bowel Syndrome
- ☐ Inflammatory Bowel Disease
- ☐ Crohn's
- ☐ Ulcerative Colitis
- ☐ Gastritis or Peptic Ulcer Disease
- ☐ GERD (reflux)
- ☐ Celiac Disease
- ☐ Other ____________________________

Cardiovascular
- ☐ Heart Attack
- ☐ Stroke
- ☐ Elevated Cholesterol
- ☐ Hypertension (high blood pressure)
- ☐ Other ____________________________

Inflammatory/Autoimmune
- ☐ Chronic Fatigue Syndrome
- ☐ Autoimmune Disease
- ☐ Rheumatoid Arthritis
- ☐ Lupus SLE
- ☐ Immune Deficiency Disease
- ☐ Poor Immune Function (Frequent Infections)
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Multiple Chemical Sensitivities
- ☐ Latex Allergy
- ☐ Other ____________________________

Metabolic/Endocrine
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Hypoglycemia
- ☐ Metabolic Syndrome
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Endocrine Problems
- ☐ Infertility
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Frequent Weight Fluctuations
- ☐ Bulimia
- ☐ Anorexia
- ☐ Eating Disorder (non-specific)
- ☐ Other ____________________________

Cancer
- ☐ Type ______________________________
- ☐ Type ______________________________

Genital and Urinary Systems
- ☐ Kidney Stones
- ☐ Gout
- ☐ Frequent Yeast Infections
- ☐ Erectile or Sexual Dysfunction

Respiratory Diseases
- ☐ Asthma
- ☐ Chronic Sinusitis
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sleep Apnea
- ☐ Other ____________________________

Skin Diseases
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Melanoma
- ☐ Skin Cancer: Type _________________

Neurologic/Mood
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Headaches
- ☐ Migraines
- ☐ ADD/ADHD
- ☐ Memory Problems
- ☐ Parkinson's disease
- ☐ Multiple Sclerosis
- ☐ Other Neurological Problems

Preventative Tests and Date of Last Test
- ☐ Full Physical Exam ________________
- ☐ Bone Density _____________________
- ☐ Colonoscopy _____________________
- ☐ Cardiac Stress Test _________________
- ☐ EBT Heart Scan ___________________
- ☐ EKG ______________________
- ☐ Hemoccult Test-stool test for blood ___________________________________
- ☐ MRI ____________________________
- ☐ CT Scan _________________________
- ☐ Upper Endoscopy __________________
- ☐ Upper GI Series ___________________
- ☐ Ultrasound _______________________

Surgeries and Date
- ☐ Appendectomy ____________________
- ☐ Hysterectomy _____________________
- ☐ Gall Bladder ______________________
- ☐ Hernia __________________________
- ☐ Tonsillectomy ____________________
- ☐ Dental Surgery ___________________
- ☐ Joint Replacement Knee/Hip ___________________________________
- ☐ Heart Surgery:
  Type ____________________________
  Date ____________________________
- ☐ Other: Type ______________________
  Date ______________________

Section 4:

The Patient, by signing below, affirm that they have read all pages of this document, understand its contents, have had all of their questions answered if any, and attest to the accuracy of the information provided therein.

Pregnancy Verification (female patients only). Please initial: __________ I am pregnant __________ I am not pregnant

Consent to Treatment of Minor Child (for parents/guardians of children under 18). Please initial:

I hereby authorize Natural Healthcare Center, its employees, agents, and/or contractors and whomever he/she may designate as assistant to administer treatment as deemed necessary to my child or guardian child. Initials: __________

Print name: (☐ self ☐ parent or legal guardian): ____

Signature: (☐ self ☐ parent or legal guardian): ____

Date: _______________________